1	EDMUND G. BROWN JR., Attorney General		
2	of the State of California MARC D. GREENBAUM		
3	Supervising Deputy Attorney General JENNIFER S. CADY, State Bar No. 100437		
4	Deputy Attorney General 300 So. Spring Street, Suite 1702		
5	Los Angeles, CA 90013 Telephone: (213) 897-2442		
6	Facsimile: (213) 897-2804 E-mail: Jennifer.Cady@doj.ca.gov		
7	Attorneys for Complainant	·	
8	BEFORE THE BOARD OF REGISTERED NURSING		
9	DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA		
10	·		
11	In the Matter of the Accusation Against:	Case No. 2009 - 293	
12	BRYANT CELEDIO 19926 Lorne Street	ACCUSATION	
13	Winnetka, CA 91306		
14	Registered Nurse License No. 642839		
15	Respondent.		
16		•	
17	Complainant alleges:		
18	PARTIES		
19	1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation		
20	solely in her official capacity as the Executive Officer of the Board of Registered Nursing,		
21	Department of Consumer Affairs.		
22	2. On or about August 12, 2004, the Board of Registered Nursing issued		
23	Registered Nurse License Number 642839 to Bryant Celedio (Respondent). The Registered		
24	Nurse License was in full force and effect at all times relevant to the charges brought herein and		
25	will expire on August 31, 2010, unless renewed.		
26	<u>JURISDICTION</u>		
27	3. This Accusation is brought before the Board of Registered Nursing		
28	(Board), Department of Consumer Affairs, under the authority of the following laws. All section		
	1		

references are to the Business and Professions Code unless otherwise indicated.

- 4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.
  - 6. Section 2761 of the Code states, in part, as follows:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct, which includes, but is not limited to, the following:
- (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
- (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."
  - 7. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or

injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

## COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

## CONTROLLED SUBSTANCES / DANGEROUS DRUGS

Dilaudid is a trade name for Hydromorphone, an Opium derivative, which is classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, and is a dangerous drug within the meaning of Business and Professions Code section 4022.

1. To protect their privacy, patients are referred to by their medical chart number, rather than their names.

12. Morphine / Morphine Sulfate, a narcotic substance, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M) and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

Demerol, a brand of meperidine hydrochloride, a derivative of the narcotic substance pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

#### STATEMENT OF FACTS

14. In August 2004, Respondent began working as a Registered Nurse in the emergency department at Kaiser Permanente Hospital, located at 5601 De Soto Avenue, in Woodland Hills, California. Kaiser utilized an automated, computerized medication dispensing system named "PYXIS." The PYXIS system is serviced by the facility's pharmacy and medications can only be accessed or withdrawn by authorized staff, including registered nurses, using their own unique personalized access code.

15. An audit of Respondent's narcotic transactions for the period of December 20, 2005 though January 19, 2006, revealed a higher withdrawal rate for Demerol, Morphine, and Dilaudid compared to other unit nurses. The audit revealed numerous narcotic discrepancies by Respondent and that Morphine, Dilaudid and Demerol was unaccounted for by Respondent. The medical records revealed the following narcotic discrepancies and medication errors:

a) Medical Chart #9796992: On or about December 21, 2005, at 2:40 a.m., the patient's physician issued an order for Morphine 2 mg IV. PYXIS records indicate that Respondent withdrew 10 mg of Morphine for this patient at 5:17 a.m. The patient's records indicate that Respondent "medicated the patient as ordered," but do not reflect the amount or time

administered. The was no record of wastage of the 8 mg, leaving 8 mg of Morphine unaccounted for by Respondent.

- b) Medical Chart #14282814: This patient did not have a physician's order for Morphine. PYXIS records indicate that on December 27, 2005, at 2:35 a.m., Respondent withdrew 10 mg of Morphine for this patient. PYXIS records further show that Respondent administered 2 mg of Morphine and wasted 8 mg. There was no documentation on the patient's medical record that the Morphine was administered, leaving at least 8 mg of Morphine unaccounted for by Respondent.
- Medical Chart #8157833: On or about December 28, 2005, at 3:20 a.m., the patient's physician issued an order for Demerol 50 mg IVP. PYXIS records reflect that Respondent withdrew Meperidine HCL (Demerol) 50 mg at both 3:46 a.m. and 3:47 a.m. for this patient. Respondent documented on the patient's record that he administered the 50 mg of Meperidine HCL at 3:45 a.m. No records reflect that the additional 50 mg of Meperidine HCL was administered or wasted, leaving 50 mg of Meperidine HCL unaccounted for by Respondent.
- Medical Chart #17328176: On or about December 29, 2005, at 4:11 a.m., the patient's physician issued an order for Demerol 25 mg IV. PYXIS records indicated that Respondent withdrew Meperidine HLC (Demerol) 100 mg at 4:22 a.m.. Respondent documented on the patient's records that Meperidine HLC (Demerol) 25 mg was administered at 4:20 a.m., leaving 75 mg of Meperidine HLC (Demerol) unaccounted for by Respondent.
- Medical Chart #99270209: On or about December 31, 2005, at 5:34 a.m., the patient's physician issued an order for Morphine 4 mg IV. PYXIS records indicated that Respondent withdrew Morphine 10 mg at 5:39 a.m.. Respondent documented on the patient's records that Morphine 4 mg was administered at 5:40 a.m.. There was no record that Morphine 6 mg was

h)

wasted, leaving 6 mg of Morphine unaccounted for by Respondent.

- Medical Chart #17040872: On or about January 1, 2006, at 9:45 p.m., the patient's physician issued an order for Morphine 3 mg IV. PYXIS records reflect that Respondent withdrew Morphine 10 mg at 10:03 p.m..

  Respondent documented on the patient's records that he administered Morphine 3 mg at 10:10 p.m.. There was no record that Morphine 7 mg was wasted, leaving 7 mg of Morphine unaccounted for by Respondent.
- Medical Chart #1523609: On or about January 6, 2006, at 10:30 p.m., the patient's physician issued an order for Dilaudid 1-2 mg IV. PYXIS records reflect that Respondent withdrew Hydromorphone (Dilaudid) 2 mg vial at 11:29 p.m.. No documentation was reflected on the patient's records that the narcotic was administered; "refused" was documented next to the Dilaudid order. There was no record that the Hydromorphone (Dilaudid) 2 mg was administered or wasted, leaving Hydromorphone (Dilaudid) 2 mg unaccounted for by Respondent.
  - Medical Chart #17086425: On or about January 10, 2006, at 2:45 a.m., the patient's physician issued an order for Demerol 12.5 mg IV. PYXIS records reflect that Respondent withdrew 100 mg of Meperidine (Demerol) at 3:48 a.m.. An entry in PYXIS records, at 4:38 a.m., reflects that Respondent administered 25 mg of Meperidine (Demerol) and wasted 75 mg. The PYXIS records further reflects that, at 4:38 a.m., Respondent administered 12.5 mg of Meperidine (Demerol) and wasted 37.5 mg. There was no record of Respondent withdrawing this 50 mg of Meperidine (Demerol). There was no documentation in the patient's record that Respondent administered any Meperidine (Demerol) and the nursing notes reflect that, at 3:45 a.m., Respondent documented, "denies pain."
- i) Medical Chart #16606354: On or about January 17, 2006, at 10:05 p.m., the patient's physician issued an order for Morphine 5 mg slow IV.

PYXIS records reflect that Respondent withdrew Morphine 10 mg at 11:54 p.m. and, on January 18, 2006, at 4:00 a.m., wasted Morphine 10 mg. Patient records reflect that the patient was discharged from the hospital at 11:45 p.m. on January 17, 2006. Removal of Morphine 10 mg after the patient was discharged was a unauthorized removal of a narcotic.

16. Based upon the results of the audit, Kaiser planned to terminate Respondent's employment due to his failure to adhere to the hospital's policies and procedures regarding narcotics and possible drug diversion. On or about February 7, 2006, Kaiser accepted Respondent's resignation in lieu of termination.

### FIRST CAUSE FOR DISCIPLINE

### (Unprofessional Conduct)

17. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivisions (a)(1) and (d), on the grounds of unprofessional conduct and that Respondent was incompetent and / or grossly negligent in that he exhibited a pattern of medical errors and unaccounted for medication withdrawals, as more fully set forth above in paragraphs 14 through 16, that had the potential to endanger patient's health.

### SECOND CAUSE FOR DISCIPLINE

# (Falsified or Grossly Inconsistent Patient / Hospital Records)

18. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (e), in that Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patients records, as more fully set forth above in paragraphs 14 through 16.

#### THIRD CAUSE FOR DISCIPLINE

#### (Use of Controlled Substances)

19. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (b), in that Respondent used controlled substances and / or dangerous drugs in a manner dangerous to himself, to other persons, or the public. The circumstances are as follows:

1	a) On or about May 17, 2007, Respondent voluntarily submitted to a drug		
2	screen. The drug test was positive for amphetamines and		
3	methamphetamines.		
4	<u>PRAYER</u>		
5	WHEREFORE, Complainant requests that a hearing be held on the matters herein		
6	alleged, and that following the hearing, the Board of Registered Nursing issue a decision:		
7	1. Revoking or suspending Registered Nurse License Number 642839, issued		
8	to Bryant Celedio.		
9	2. Ordering Bryant Celedio to pay the Board of Registered Nursing the		
10	reasonable costs of the investigation and enforcement of this case, pursuant to Business and		
11	Professions Code section 125.3;		
12	3. Taking such other and further action as deemed necessary and proper.		
13			
14	DATED: 5/15/09		
15			
16	RUTH ANN TERRY, M.P.H., R.N. Executive Officer Board of Registered Nursing Department of Consumer Affairs		
17			
18			
19	State of California Complainant		
20	•		
21			
22	LA2008600386		
23	Celedio Acc.wpd		
24			
25			
26			
27			